DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

10-39-8

11-93-60

PRINTED: 09/15/2020 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
FOL4	445075		B WING_		09/14/2020	
l .	PROVIDER OR SUPPLIER URE HEALTHCARE OF	F MADISON		STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 000	was conducted by the September 14, 2020 in compliance with a control regulations a	ed Infection Control Survey he State Agency on D. The facility was found to be 12 CFR §483.80 infection and has implemented the	F 000			
F 550 SS=D	Prevention (CDC) reprepare for COVID-cited. Total census 4 Resident Rights/Exe CFR(s): 483.10(a)(1) §483.10(a) Resident	ercise of Rights ()(2)(b)(1)(2) t Rights.	F 550	How corrective action will be		
	self-determination, a access to persons a outside the facility, in this section. §483.10(a)(1) A facility with respect and dig resident in a manner promotes maintenar her quality of life, recommendation.	right to a dignified existence, and communication with and and services inside and including those specified in lity must treat each resident and in an environment that are or enhancement of his or cognizing each resident's		accomplished for those reside found to have been affected by deficient practice: a. Administrator educated LPN Assistance with Meals Policy 2. How the facility will identify other residents having the potential affected by the same deficient	y the	
	promote the rights of §483.10(a)(2) The faraccess to quality can severity of condition, must establish and no practices regarding the provision of services residents regardless §483.10(b) Exercise	tuality. The facility must protect and ste the rights of the resident. 10(a)(2) The facility must provide equal is to quality care regardless of diagnosis, by of condition, or payment source. A facility establish and maintain identical policies and these regarding transfer, discharge, and the on of services under the State plan for all into regardless of payment source. 0(b) Exercise of Rights. sident has the right to exercise his or her		practice: a. All residents have the potent be affected by alleged deficing practice therefore; observation rounds were completed 9/21 no concerns to the concerns of the conc	ent onal	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: QMHH11

Facility ID: TN1915

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
445075		B. WING			09/14/2020		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				431 LARKIN SPRING RD			
SIGNATURE HEALTHCARE OF MADISON			MADISON, TN 37115				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO TAG (CROSS-REFERENCED TO THE APPR DEFICIENCY)		BE	(X5) COMPLETION DATE	
f 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the		F		or systemic changes made, to ensuthat the deficient practice will not rea. Staff Development Coordinato educate all Licensed Nursing and CNA's on Assistance with Policy b. Staff Development Coordinato	at the deficient practice will not recur: Staff Development Coordinator to educate all Licensed Nursing Staff and CNA's on Assistance with Meals Policy Staff Development Coordinator to conduct Assistance with meals competency with all Licensed Nursing Staff and CNA's	
	exercise of his or he subpart. This REQUIREMEN by: Based on the facility review, observation failed to treat 1 (#1) during the noon me Licensed Practical Nassisting Resident # The findings include Review of the facility Meals, dated 6/27/1 cannot feed themse to safety, comfort ar standing over reside meals" Review of the medic #1 was admitted to 10 re-admitted on 3/27/included Parkinson's	er rights as required under this at it is not met as evidenced by policy review, medical record and interview, the facility of 24 residents with dignity alon 9/14/2020 related to a Nurse(LPN) standing while the facility of the facility of the facility of the facility of the facility on 8/25/15 and for the facility of			corrective actions to ensure that the deficient practice is being corrected and will not recur: a. Nursing Administration, included Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing Weekend RN Supervisor will conduct assistance with mea observations x5 weekly x4 weeking them x2 weekly x4 weeks, and random thereafter. b. All findings will be reported monthly during the QAPI committee which includes but not limited to the Administrate Medical Director, Director of Nursing, ADON, Staff Develop Coordinator, MDS Nurse, Diem Manager, Maintenance Director Social Services Director. All audit findings will be reported with recommendations and resolution until substantial compliance in	and ding and dis eeks, d at t is or, coment tary tor,	10/3/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		445075	B. WING		09	/14/2020	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 431 LARKIN SPRING RD MADISON, TN 37115				
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	Review of the Quart (MDS), dated 7/16/2 had a Brief Interview indicating the resided Continued review stranspervision with eat assist. Observation of Resident #1 with he During an interview LPN #1 confirmed sassisting Resident #1 During an interview During an interview assisting Resident #1	terly Minimum Data Set 2020, showed Resident #1 w Memory Score of 13, ent was cognitively intact. howed Resident #1 required ing with a 1 person physical dent #1 on 9/14/2020 at PN #1 stood to assist r meal. on 9/14/2020 at 5:08 PM, he was standing while 11 with the noon meal. on 9/14/2020 at 7:30 PM, the med LPN #1 was to sit while	F5				
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